MEDICAL CONDITIONS EMERGENCY CARE PLAN

This section must be completed by a HEALTH CARE PROVIDER: (MD, DO, ND, DMD, DC, PA, ARNP or CNM)

Child Name_____ **DOB** _____ /_____ /_____

Allergies: _____

Current Medications: _____

Does this child have, or previously had, a medical condition other than: allergies, diabetes, asthma, seizures, or HIV? (Examples: heart problems, epilepsy, dizzy spells)

Check: ☐ **Yes** ☐ **No**

If yes, please specify which conditions they have currently, or previously had, and provide information on any special accommodations that may be required:

_____

_____

Does this child have any cognitive or social conditions that you are aware of such as phobias, motor skill disorders, ADHD, anxiety etc.?

Check: ☐ **Yes** ☐ **No**

If yes, please specify which conditions they have currently, or previously had, and provide information on any special accommodations that may be required:

_____

_____

Does this child have any developmental conditions that you are aware of, such as autism, sensory processing, down syndrome, spina bifida, etc.?

Check: ☐ **Yes** ☐ **No**

If yes, please specify which conditions they have, or previously had, and provide information on any special accommodations that may be required:

_____

_____

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Does this child have any physical limitations that affect their ability to participate in GYMNASTICS activities or which may be aggravated by excessive movement, such as low muscle tone, birth defects, joint pain or swelling, concussion, etc.?

Check: Yes No

If yes, please specify which conditions they have, or previously had, and provide information on any special accommodations that may be required:

_____

_____

Please advise us of any other conditions or illnesses that the child has, or previously had, that may require us to assist them in an emergency.

_____

_____

The child may participate in recreational GYMNASTICS activities. [ ] Yes [ ] No

Activity restrictions: [ ] None [ ] Some Restrictions; please explain:

_____

Please attach any additional information that may be necessary for SGA staff to identify and treat medical condition(s) that the child has, or previously had, in the case of an emergency.

_____

Licensed Health Care Provider's Signature Date: Phone:

MEDICAL CONDITIONS EMERGENCY CARE PLAN

This section must be completed by a LEGAL PARENT/GUARDIAN:

Emergency Medication(s) to be administered:

_____

Please check only one box:

□ In the case of an emergency I request that authorized persons at STC administer the above listed medication.

□ I request that my child be allowed to self-carry and/or self-administer this medication. My student and I understand the responsibility of self-carrying medication at STC and recognize that the STC staff will not track compliance, expiration, or amount. I agree to hold harmless and indemnify STC and STC's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by my student.

□ I am 18 years old and signing this form on my own behalf. I agree to hold harmless and indemnify STC and STC's officers, employees, and agents against all claims, judgments, or liabilities arising out of my self-administration and carrying of medication.

- I request this medication to be given as ordered by the licensed health professional (i.e.: doctor)

- I understand that the medication(s) will be given in the case of a medical emergency by trained and supervised STC staff.

- I release STC and STC's officers, employees, and agents from any liability in the administration of this medication at any STC facility.

_____

Student First and Last Name

_____

Parent / Guardian First and Last Name

_____ _____

Parent / Guardian Signature **Relationship to Student**

Today's Date: _____ Phone: _____